Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $6,971.77 for dates of service 02/05/01 and 02/09/01.

   b. The request was received on 02/02/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA-1450/UB-92
   c. TWCC 62 form/Medical Audit summary dated 06/22/01
   d. EOB(s) from other carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 03/26/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 03/26/02. The respondent did not respond to the request for the 14 day response to the request for medical dispute. It's initial response is reflected in Exhibit II.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: TWCC 60:
"(Provider) objects to The (Carrier's) description, '…f/r rates are based on national statistical data for consumption of resource & national average charges for ambulatory surgeries'."…. The (Carrier's) statements are not sufficiently explanatory to enable (Provider) to fully respond, thereby, denying (Provider) of its due process rights guaranteed under both the Texas Constitution and the United States Constitution…. The procedure (92289/360) is handled as a DOP procedure in that all pertinent information is attached….HCPCS codes should be reimbursed as provided in the DME Ground Rules….There is no fee guideline adopted by the TWCC or Rule which reduces 'fair and reasonable´ [sic] to $0.00."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 02/05/01 and 02/09/01.

2. Per the TWCC 60, the provider billed the carrier $6,971.77 for services rendered on 02/05/01 and 02/09/01. Date of service 02/05/01 will not be addressed. The provider failed to submit any medical documentation, HCFA, or EOB/medical audit for date of service 02/05/01, therefore, no reimbursement is recommended.

3. The amount the carrier reimbursed the provider $812.20 for services rendered on date of service 02/09/01.

4. The correct amount in dispute for date of service 02/09/01 is $5,766.57.

5. The services provided by the provider include such items as O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy services, Radiology services, anesthesia equipment services, EKG/ ECG monitor services, and Recovery Room services.

6. A medical audit dated 06/22/01 states, "The outpatient procedure was reimbursed at the (Carrier's) fair and reasonable. Our f/r rates are based on national statistical data for consumption of resources and national average charges for ambulatory surgeries."
The carrier denied billed services by codes:
"M- THE REIMBURSEMENT FOR THE SERVICES RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B).";
"M- FAIR AND REASONABLE REIMBURSEMENT FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICE' LINE ITEM."

7. After reviewing all information in the case file, no other EOB(s) or medical audits were noted. The Medical Review Division's decision is rendered based on denial codes submitted to the provider prior to the date of this dispute being file

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"

Texas Labor Code Section 413.011(b) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate."

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The provider submitted EOB(s) from other carriers showing the payment ratio of carrier reimbursement to provider billed charges. The average percentage of reimbursement is 85% per the submitted EOB(s). Regardless of the carrier's application of it's methodology, lack of methodology, or response the burden is on the provider to show that the amount of reimbursement requested is fair and reasonable. The burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. The provider's documentation is EOB(s) or is based on EOB(s). However, analysis of recent decisions of the State Office of Administrative Hearings indicate minimal weight is given to EOBs for documenting fair and reasonable reimbursement. The willingness of some carriers to provide reimbursement at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(b) of the Texas Labor Code. The EOB(s) prove no evidence of amounts paid on behalf of managed care patients of ASC(s) or on behalf of other non-workers' compensation patients with an equivalent standard of living. Therefore, based on the evidence available for review, the provider is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 26th day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

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